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news

BRITISH SOCIETY OF GASTROENTEROLOGY

Message from the President

Professor Martin Lombard, BSG President

What a summer it's been, and for once the turbulence and inaccurate forecasts have not been all about the weather. Who would have predicted at the beginning of this year that we would have a new prime minister and cabinet, that we would have voted to leave the EU, that elections in foreign lands could be so intriguing, that our immediate past president was all the while honing his acting skills for his future career and that a premonition by the president before that, in his Summer 2014 newsletter, would be turned over to give the BSG its second only female president to take office before the decade ends.

So it is with some trepidation that I take over the helm of this august society and set a course into the future with maybe a dodgy compass and a worn out map that is becoming difficult to read. In many realms of our lives it remains the case that the best guide to the future is the past, but that should not mean we relive history and cannot mean we rely on certainties. Benjamin Franklin supposedly said there were only two certainties in life, "death and taxes", but in the NHS we can also be certain of two things: our patients' needs will change and so also will the way we strive to address them.

During the last 30 years in gastroenterology and hepatology, among many other changes, we have witnessed the transformation from surgical to antibiotic treatment for peptic ulcer disease, the diagnostic identification and development of a cure for chronic hepatitis C, the introduction of biologic (and 'biosimilars') treatment for chronic inflammatory bowel disease, and the growth in diagnosis and management of gastrointestinal cancers which now comprise more one in five of all cancers in the UK and more than 25% of annual deaths from cancer. As a group, by my estimation we diagnose more than 80% of all gastrointestinal cancers and provide definitive or ongoing treatment for probably half of those. We have seen the emergence of so-called 'lifestyle diseases' as a major threat to health and contribution to overall morbidity, none more so than alcohol related and non-alcohol related liver disease.

For clinicians, the nature of the job has changed but remains the same in many ways. We have seen overall a move to more specialisation and subspecialisation driven by a requirement of more efficiency and better outcomes. Ward based work has become predominantly liver related in most acute hospitals; virtually all diagnostic and most therapeutic procedures are now undertaken on a day case or ambulatory outpatient basis. Seven day services and twice daily ward rounds with 'on service' rotas have become the norm for most gastroenterologists and hepatologists. We have been at the forefront of inventing new clinical roles for specialist nurses (more than 20 different job descriptions to describe the special interest or special skills of this workforce) during the past 25 years in addition to working alongside dieticians, nutritionists, intravenous access teams, physiologists and clinical technicians (apologies for any omissions!), not to mention our surgical, radiology and pathology colleagues on whom we rely. We will presently also embrace the emergence of non-medical, non-nursing physician assistants.

What all of this tells us is that, as professionals, we have been quite nimble in adapting to challenges and have embraced change. Just under half of the membership of the BSG are consultant gastroenterologists and hepatologists, a further 20% are made up of training medical grades and the remainder are our workforce colleagues that we rely on every day to face the clinical challenges and provide care, diagnosis and treatment for the patients we serve. The gender representation within medical schools and the medical workforce has also become more balanced, although in gastroenterology, as in other procedure based acute specialties, we still have some way to go to achieve full demographic parity. However, in the working environment of the wards, clinics and endoscopy units taken as a whole, possibly only 15% of the workforce is medical and for the remainder we continue to develop their skills and delegate tasks previously only performed by qualified doctors. Successful units engender a team spirit, equity and camaraderie which improve quality of care and can enhance our working experience where we spend up to one-third of our lives. As a professional membership organisation we will need to consider how we can better represent our workforce and colleagues.

So at the AGM this year your executive committee proposed that the BSG becomes more representative of its workforce, in terms of proportionality, values and representative activities. We hope we can ensure that the BSG has a secure platform from which we can shape our future. Innovation will be crucial in shaping our future: "It is not the strongest of species nor the most intelligent that survives, it is the one that is most adaptable to change"—Charles Darwin.

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The BSG can, has already and will continue to adapt to change, and we want to ensure we provide value and to grow our membership and influence. Our very vibrant and active sections will continue to have a significant role in shaping our collective future. Compared with other specialties we remain a very popular career choice but we should not be complacent—the working environment for our very junior colleagues is difficult and challenging, and their choice of specialty and career is complex. Showcasing creating the innovative, exciting, varied and learning environment that is gastroenterology as early as possible in medical schools and foundation years is the best way of securing our future. We have also been more creative and accommodating than any other specialty for the non-medical workforce and we need them to play a much more active role in our future. We will embark on a series of workshops and surveys to better understand what more we can do to support you and your teams through the principal activities of the Society, which remain education, training, research and service. There are many ways for individuals to become involved in the activities of the Society so please do get in touch or speak to any of the officers or section members to learn more. The BSG is an amazing organisation which is very active on your behalf throughout the year, not just at the annual meeting, so come on board and let's set sail.....and loan us your compass!

Please get in touch at the email address below. We would very much appreciate your comments and suggestions: president@bsg.org.uk

Endoscopy matters

BSG Endoscopy was delighted to contribute to a highly successful annual meeting in Liverpool. We provided a day of live endoscopy from Aintree Hospital, where a wide range of cases were delivered, demonstrating the real world of live endoscopy. We delivered a broad endoscopy programme which included presentation of the new standards for upper gastrointestinal endoscopy, bowel cancer screening sessions, and combined radiology, gastroduodenal and colorectal sessions. Highlights were Dr Nagi Reddy's inspirational foundation lecture and Dr Oppong's excellent Hopkins lecture. BSG continues to develop a national programme of live endoscopy, and Endolive 2 will be delivered on 2–3 March 2017. The meeting will be held at ICC Birmingham and live cases will be demonstrated from St Mark's London and Glasgow Royal. The meeting will once again be competitively priced for delegates, and those attending will receive discounted registration for the BSG annual meeting in Manchester in June 2017.

Over recent years the UK has taken huge strides forward in delivering high quality colonoscopy, and has started to address the quality of ERCP. Upper gastrointestinal endoscopy is often the poor relation, and under the leadership of Krish Ragunath and Andy Veitch, BSG has now developed standards for upper gastrointestinal endoscopy. Studies have demonstrated a miss rate for upper gastrointestinal cancer at endoscopy of approximately 10% on average. We have the opportunity with gastroscopy to emulate the huge quality improvements achieved for colonoscopy. This is particularly important now that early upper gastrointestinal neoplasia, including intramucosal cancer, can be treated effectively endoscopically. Evidence based standards have been developed that will be published as part of a BSG/AUGIS position statement, and then be adopted by JAG. These standards were presented at a well attended session at the BSG annual meeting, and were well received. Training will be required to improve mucosal visualisation in the upper gastrointestinal tract, and also to recognise subtle early neoplastic changes. This will be developed collaboratively between BSG and JAG.

Professor Colin Rees (left), BSG Vice President, Endoscopy and Dr Nagi Reddy (right)

Endoscopy capacity continues to be a major issue up and down the country, and BSG is working closely with government and key stakeholders to work out how we can meet the demands of growing referral numbers while keeping waiting times low. BSG are committed to ensuring that however endoscopy is delivered, quality must be high.

Liver matters

The annual BSG meeting in Liverpool was a major success with an excellent liver day and session 'The liver and the brain'. The BSG liver section is already in the process of putting together the 2017 meeting to make this an even greater success. We are always interested to hear your thoughts and suggestions on what you want from hepatology at these educational events. Please let us know!

Commentary

Recent NICE guidelines on cirrhosis and non-alcoholic fatty liver disease were finally published on 6 July (cirrhosis: https://www.nice.org.uk/guidance/ng50; non-alcoholic fatty liver disease: https://www.nice.org.uk/guidance/ng49). These are important documents with a major potential impact on liver services and the interface with primary and secondary care. Both guidelines recommend an approach of fibrosis screening in high risk groups to identify those at highest risk of having advanced liver disease. With implementation this will change local pathways from primary care and require much wider availability of tests of fibrosis. The guidelines recommend ELF markers and elastography (fibroscan, ARFIE) for assessment of fibrosis. A major challenge is that none of these methodologies to measure fibrosis is in routine clinical use at the present time. Therefore, local investment is likely to be required to implement them. These guidelines will complement the BSG's own guidelines on abnormal liver blood tests which will be available later this year. The guidelines come at an opportune time with the RCGP's announcement to make liver disease a priority.

Viral hepatitis

Public Health England published its 2016 annual report on hepatitis C in the UK to coincide with World Hepatitis Day. The full report is available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/541317/Hepatitis_C_in_the_UK_2016_report.pdf.

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For the first time, there has been a drop in mortality related to hepatitis C. However, new infection rates are not falling, and the treatment rate for hepatitis C was just 4.2% in 2015. There clearly is much further to go in extending treatment services to all who need them. The 23 hepatitis C operational delivery networks have been given a number of treatments per month with a financial penalty via a CQUIN scheme for any network that exceeds their 'run rate'. The 10 000 treatments available nationally does not match the patients that would benefit. The BSG will continue to lobby strongly for increased access to these drugs.

The James's Lind Alliance, BSG, NIHR

The James Lind Alliance alcohol related liver disease process is moving on as a partnership between BSG and the National Institute for Health Research (NIHR). The aim is to identify a top 10 list of unanswered questions about alcohol related liver disease interventions for researchers to answer. This has generated many questions. Help is needed to narrow down the questions to a shorter list to take to a final prioritisation workshop in September. You can help by completing this survey: https://www.surveymonkey.co.uk/r/2PS87VF

Lancet Commission

The 'Lancet Commission 3' will be published in December. This will outline proposed metrics in all of the major recommendations from the initial Lancet Commission report in 2014 to gauge progress. Part of the publication will be a survey of the current hepatology workforce and existing liver services in the UK. Many of you have been approached and hassled to complete the questionnaire. Thank you to all those who have responded. At the time of writing, only six hospitals in the UK have failed to respond. It would be a remarkable achievement to have 100% response, so a final plea to the last few to complete this!

Training

National recruitment into the Advanced Liver Fellow posts has been successful, with all posts filled. In October, the 2010 hepatology curriculum will be reviewed. The liver survey will help guide where hepatology training at all levels can be offered.

Dr Mark Hudson,
BSG Vice President, Hepatology

BSG 2016 Annual Scientific Meeting Report

The annual meeting was held in Liverpool at the Echo Arena on 20–23 June. The conference attracted a record number of delegates, with 2199 attendees: 97% of delegates rated the meeting and programme content as being very good/good and many stated it was the best BSG they had attended! Although there is a drive to make all meetings paperless, the majority of delegates appreciated having the conference newspaper, 'Delegates Digest', which included all the programme sessions along with special features on prize winners and section highlights. There were other firsts at the conference, including hot food, new prizes for the best abstracts, Twitter for novices sessions, screens displaying live Twitter feeds, a free power pack for every delegate, and interactive mapping, messaging and delegate finder on the conference app.

The meeting commenced with a very well attended postgraduate education day with a state of the art lecture on the microbiome, cutting edge updates in many areas of gastroenterology and interactive sessions on managing endoscopic complications throughout the day. This was followed by the Trainee Sections' novel symposium on 'gastroenterology in war zones'.

Tuesday began with free paper sessions followed by the BSG plenary. This saw Professor Michael Camilleri deliver the Sir Arthur Hurst lecture on 'advances in the management of chronic constipation and diarrhoea', the Sir Francis Avery-Jones research medal lecture from Dr Ye Oo and the New Perspectives lecture from Professor Jane Dacre, President of the Royal College of Physicians, on 'interesting times'. The highest ranking conference abstract was also showcased and the inaugural BSG Lifetime Achievement Award was presented to a very popular and well deserved recipient, Professor Chandu Bardhan. That evening also saw the popular conference party organised by our trainee section in the Albert Dock, featuring 'The Cheatles'.

The conference held several parallel symposia on all aspects of gastrointestinal and liver disease. There was a good balance of basic and clinical science symposia, state of the art lectures and clinical updates throughout the week. Many sections of the BSG had collaborated to provide 12 joint symposia, enhancing shared learning, with many sessions being interactive. Live endoscopy was reintroduced at the conference, with Wednesday seeing a full day of live links from Aintree. The sessions focused on 'getting the basics right' and were particularly popular with delegates. The Thursday Scientific Translational Master Class looked at the gut neuroendocrine system in detail, and Core also featured strongly having two sessions in the main programme in addition to their patient symposium. Live Twitter feeds were displayed on screens around the venue, and thanks go to the 'BSG Twitterati' for keeping those screens fun, dynamic and insightful!

Almost 800 abstracts were submitted, with an acceptance rate of 71%. From Tuesday to Thursday there were lunchtime poster judging rounds conducted by BSG committee members. Each and every poster was judged so authors got the chance to showcase their research and obtain feedback from experts in their field. There were also abstracts of distinction and exhibition posters, and video presenters had tablets to show their videos to interested delegates.

Some sessions at the conference were extremely popular and delegates were turned away. Room sizes will be scrutinised for the next conference but if BSG members missed any presentations at the conference they are now available on BSGtv which can be accessed on the BSG website (http://www.bsg.org.uk/). Planning is already in progress for our next conference, which will be held in Manchester on 19–22 June 2017. Put the date in your diary now!

I enjoyed the process of chairing the scientific programme committee enormously and thank all those involved in contributing to BSG 2016!

Dr Jayne Eaden, BSG Senior Secretary and Programme Committee Chair

Quality improvement

The mission of the BSG is to support its members to provide the best care and achieve the best outcomes for patients with gastrointestinal and liver diseases. As one of the ways to achieve this, the BSG has embarked on a quality improvement project through the Clinical Services and Standards Committee (CSSC). The gastroenterology community has a proven track record with the GRS and JAG, and the high standards achieved by a JAG accredited endoscopy unit. The objective of the quality improvement project is to improve standards of care across a wider set of clinical areas

outside endoscopy. Patients with gastrointestinal and liver disease will benefit from knowing that quality of care throughout the UK for such patients is actively being reviewed and improved, and that there is equality and little variation of care wherever they go. Health system regulators, funders and commissioners will be able to reference the extent to which a service is reaching agreed markers of quality and driving ongoing improvement. Gastrointestinal and liver units can use these standards as a lever to improve services. Units that adopt and meet required quality improvement standards might, if a strong case was made, be rewarded with best practice tariffs in England. Healthcare providers that achieve these standards should feel a well deserved sense of satisfaction but it is equally hoped that a culture of constant improvement can be instilled throughout services nationally. In the future, if accreditation of whole services were to become a reality, such units will be in a good position to achieve certification status.

The BSG has had discussions with the presidents and representatives from the Association of Upper Gastrointestinal Surgeons, Association of Coloproctology of Great Britain and Ireland, patient groups, representatives from the Clinical Service Accreditation Alliance (CSAA) and Liver QuEST. CSAA is a collection of colleges, professional bodies, regulators, commissioners and patients who have come together to standardise and improve the quality of healthcare service accreditation, with the Royal College of Physicians of London being the lead body. Liver QuEST will be a project familiar to many in the liver community (see BSG Summer 2016 newsletter), and has seen active participation from BSG members in pilot hospitals as a means to drive quality improvement in liver services.

We realise that the work involved in coming up with standards and measures is significant. We are also very aware of the need to ensure that the time involved for teams to provide evidence is not too burdensome or an interference with good clinical care. The quality improvement project will take time to achieve its ultimate aims and the journey is just beginning. As a starting point, we are working with leads from CSAA and Liver QuEST to develop a template and key questions from which relevant sections from the BSG will be able to build their own standards and measures.

We look forward to working with members of the BSG in this quality improvement project and welcome any feedback that you may have.

Dr Tony Tham, BSG Quality Improvement Lead and Deputy Chair, BSG Clinical Services and Standards Committee

UK IBD Registry

The inflammatory bowel disease (IBD) Registry is designed to give teams local data to manage their IBD service more effectively, while patients, clinicians and the NHS will all benefit from national audit of the safety and appropriate use of biologics and biosimilars.

The Registry provides the infrastructure to capture pseudonymised data from every IBD team in the UK and combine it with routinely collected NHS hospital statistics. Bringing this information together for the first time will help drive improvements in patient care, inform commissioning and service design, improve our understanding of long term outcomes and support IBD research.

The national IBD audit, run by the Royal College of Physicians, has driven significant improvements in both services and patient outcomes over the years. However, the programme is now coming to an end, and our goal is to move the biological therapies audit and quality improvement programme into the Registry and develop a complete biologics register. While the initial focus will be on biologics, in time, the combined UK data will become a unique resource for real world clinical effectiveness and health economic studies in IBD care.

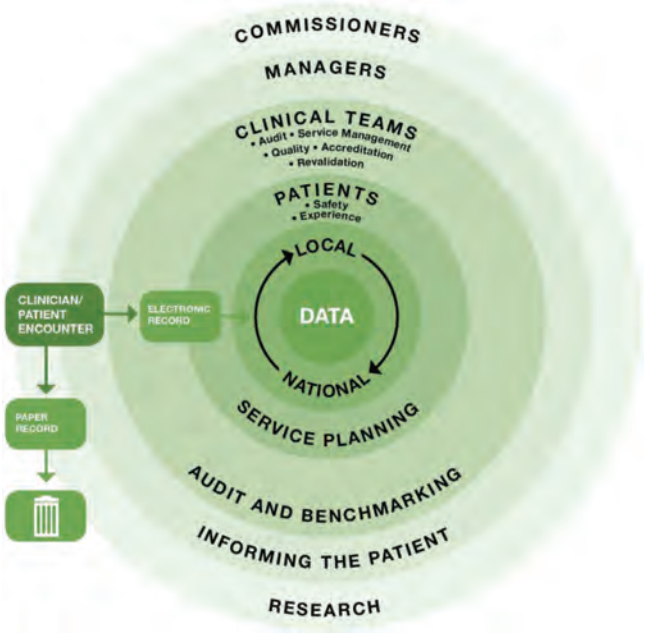
All IBD teams across the UK will be able to take part, using their choice of data entry method—an integrated patient management system, web tool or local system. Outgoing president Ian Forgacs has called on all IBD teams to match the BSG's commitment to the Registry and safeguard its success by taking part. If you are among the few who have not yet registered to join, please see below.

Transition focus on biologics

To deliver immediate local value to teams and patients, the Transition Steering Group, chaired by Ian Arnott, has proposed reporting on a set of six key performance indicators on biologics in 2016–2017, with the aim of building a UK wide register of all people receiving biological therapies for IBD by the end of 2017.

As a continuation of the biologics audit, the programme remains on the Quality Accounts list and the national clinical audit and patient outcomes programme (NCAPOP) in England.

The teams who have already started have seen significant benefits in terms of running their service and the quality of care they are able to give their IBD patients. Patients report better continuity of care. Working together, we have the chance to build an important and unique resource that will deliver real value, but we all need to participate. I urge you to join in this important project, which has the potential to put UK IBD teams on the map.



To find out more about joining the IBD Registry, contact IBDProgramme@rcplondon.ac.uk

Dr Stuart Bloom, Chair, UK IBD Registry

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Launch of the first electronic BSG workforce census

The annual workforce census of UK gastroenterology trainees and consultants has been carried out by the BSG for over 20 years. For all of this time, Mrs Chris Romaya did an admirable job of keeping track of us all as we started as trainees, moved in and out of programme and were eventually appointed to a consultant post. Chris' meticulous and personal approach has resulted in a gastroenterology workforce database which is widely acknowledged to be one of the most accurate of its kind. The BSG workforce lead uses the data on 30 September each year from this fantastic database to produce an annual workforce report. This report describes the expansion in consultant and trainee numbers, and changing workforce demographics, and is published on the BSG website in the training section:

http://www.bsg.org.uk/training/general/workforce-reports.html

Chris Romaya retired at the end of 2015 and Mr John Hayward has been appointed by the BSG to the workforce role. The time felt right to enact the change from a paper based to an electronic census. The BSG approached the Medical Workforce Unit of the Royal College of Physicians (RCP) to create the first electronic BSG census. The census forms have been sent out electronically to all UK gastroenterology consultants and trainees who will be in post on 30 September 2016. Those who have not responded after 4 weeks will be sent a reminder followed by a paper form if no electronic response is received. It will take slightly longer than usual to complete the census for the first year as we have to create a new electronic database. However, in future years you will just be updating your information so it should be much quicker. The BSG will verify consultant and trainee numbers by identifying one consultant from each trust to fill in a detailed trust census form. They will follow this up by telephone if the information is not received, to ensure that headcount data are as accurate as possible. Apart from the obvious time saving advantages of electronic data entry, it should enable the creation of a demographic dashboard which can be made available on the website so that you can interrogate the data yourselves.

We hope to maintain the high return rate for the census as the BSG workforce report is very important for planning the workforce of the future. It is used by the workforce lead to negotiate with Health Education England (HEE) and other education providers over the number of gastroenterology trainees (NTNs) required in 7–10 years. We try to predict the number of gastroenterology consultants needed to fill advertised posts to serve the changing needs of the UK population of the future. It is used by trainees to judge the number of consultant posts likely to be advertised at the time they will obtain their CCT. It is used by consultants and trusts to benchmark the trust's gastroenterology department against recommended numbers and in comparison with other trusts of a similar size. Services also use the data to help time consultant post advertisements to coincide with trainees obtaining their CCT who might wish to apply. The RCP uses the BSG workforce data to check the accuracy of their own census data, and the Centre for Workforce Intelligence uses it to help advise HEE on the changing workforce. The workforce data have also been invaluable for a gastrointestinal endoscopy workforce review, due to be published soon, to help secure the future gastrointestinal endoscopy workforce supply.

Recently we have highlighted the following workforce issues:

1. Regional variation in consultant and trainee provision per weighted capita.
2. Consultant recruitment difficulties with regional variation. This has occurred because of a dramatic increase in demand for consultant gastroenterologists in the past 4 years that was not predicted, and was therefore not planned for by HEE.
3. The need for more flexible working patterns in the specialty due to an expansion in the proportion of female trainees and consultants, and more consultants wishing to work less than whole time.
4. Difficulty filling short term trainee rotation gaps, exacerbated by the abolition of LAT posts in England, which impacts on the training of the remaining trainees and could mean that training programme directors are less likely to allow trainees to go out of programme.

I am well aware of the 'survey fatigue' that we all feel, and that workloads continue to rise as trusts 'sweat the assets' to cope with lengthening waiting lists and try to improve length of stay. I would be very grateful if you could make the time to complete this survey as soon as you can so that the BSG can continue to produce its high quality workforce reports, and I send you my sincere thanks in anticipation.

Dr Melanie Lockett, BSG Workforce Lead

Apply to be a member of the BSG International Committee

The BSG Council has agreed to move forward with the establishment of an International Committee and is seeking applications from BSG members to form its inaugural membership. Many BSG members have established links internationally and undertake various educational and training projects in these countries. The BSG continues to support many projects led by members through its grants programme and wishes to establish a committee to embed and expand productive partnerships internationally so that patients and professionals can benefit from UK expertise and reciprocal links are maintained. Committee members will appointed by competitive application and interview process (valid for an initial term of 3 years) and will report to BSG Council and Trustees through the International Secretary. Applications are sought from members of all categories in any area of practice related to gastroenterology and hepatology. Experience of international projects or established international links is welcome but not essential. An active track record in education, training, research or clinical practice is equally valid.

A job description is available on the BSG website (http://www.bsg.org.uk/international/funding-opportunities/index.html). Please send a brief CV (2 pages max.) and a statement of application detailing why you would like to be appointed to the committee to Christine O'Shea (c.oshea@bsg.org.uk). Applications will close at 5pm on Monday 31st October 2016. Interviews by a panel of officers, Council members and Trustees will take place in early December 2016 (exact date tbc).

Learning lessons and supporting service improvement

In August, I issued an initial call to BSG members through the electronic newsletter for their insights into how they have succeeded in making the case for service improvements. It is my intention to share these insights more widely for the benefit of the whole membership.

At various points during our most recent annual meeting, and indeed before, it has been clear to me that a great deal of great work goes on in gastrointestinal and liver units up and down the country. Teams have taken a particular service issue and implemented changes that have

improved patient care, access or quality. This is juxtaposed by a wider feeling of pressure in the system driven by what seems like inexorable demand.

Often an innovation will have required the development and 'selling' of a business case locally. This experience and know-how is in my mind something that could be used to support colleagues in another hospital or service. Of course there will be issues particular to a service or local health economy but equally there is a great deal of commonality and certainly an opportunity to share what did (and did not) work through a central repository of information. No matter how large or small the change, we would like to hear further details (approach, business case, outcomes, shared learnings, cost savings, gain shares, etc) so that case studies and other resources can be compiled.

The BSG has also recognised the importance of commissioners of gastrointestinal and liver services. Through a series of regional workshops driven by CSSC's regional representatives we have produced a report that can support members in making successful business cases. The report (available at http://www.bsg.org.uk/clinical/news/index.html) contains simple elements like a top 10 'tips for success' and a 'business case checklist' as well as specific outputs from the workshops (common challenges and actions) and specific case studies. While 'commissioning' is an English centric term, the lessons are applicable in other health systems, albeit with different labels and funding mechanisms.

I look forward to hearing from members and continuing this important dialogue and process of shared learning. Please feel free to contact me by email (r.gardner@bsg.org.uk).

Richard Gardner, BSG Chief Executive

BIG meeting - 27th - 28th April 2017

We would like to invite colleagues to the second BIG (British and Irish Gastroenterology) meeting which will be held in Belfast in 2017. This is a BSG, USG and ISG satellite meeting, which was first held in 2013 in Belfast and was extremely successful and attracted delegates from Britain, Ireland and further afield.

We will have an exciting programme of national and international speakers over the 2 days for gastroenterologists, surgeons, trainees and allied health professionals.

Topics on the Thursday session will include functional gastrointestinal and surgical hepatology and 'hot topics' in inflammatory bowel disease (IBD). The Friday session will include IBD and endoscopy. There will also be parallel nursing sessions for different specialties. The full programme is being finalised and further details will be available soon.

We would like to invite our colleagues to consider attending our meeting and to enjoy the local sites and hospitality in Belfast. Registration details will be available in September.

For further information please contact: help@usge.co.uk

Dr Patrick Allen, Ulster Society of Gastroenterology

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